PA15-2004: 2ND OPHTHALMIC ALLERGY MEDICATIONS REQUEST

RI MEDICAL ASSISTANCE PROGRAM
PRIOR AUTHORIZATION REQUEST FORM

NOT REQUIRED FOR RECIPIENTS UNDER 21 YEARS OF AGE.

CLIENT NAME: _____ DOB: _____ MEDICAID ID NUMBER: _____
PRESCRIBER NAME: _____ PRESCRIBER DEA #: _____
PRESCRIBER OFFICE ADDRESS: _____
_____
OFFICE PHONE NUMBER ( ) _____
REQUESTER NAME: _____ RN /MD /R.PH / ____
PHONE NUMBER: ( ) _____ FAX NUMBER: ( )_____
DRUG REQUESTED: _____ STRENGTH:_____ QTY / FILL: _____
START DATE: _____ DOSING FREQUENCY: _____

CRITERIA SPECIFICATIONS ARE AVAILABLE BY CALLING **(401) 784-8100** OR AT WEB ADDRESS
www.dhs.ri.gov/dhs/heacre/provsvcs/mpharpa.htm

HAS THE PRESCRIBER TRIALED THERAPY WITH ONE OF THE PREFERRED AGENTS? YES / NO

- OPCON-A®, NAPHCON-A®, OR VISINE-A®, (NAPHAZOLINE/PHENIRAMINE COMBINATIONS)
- VASOCON-A® (NAPHAZOLINE/ANTAZOLINE COMBINATIONS)

IF NO, PLEASE EXPLAIN WHY?

HAS THE PATIENT BEEN DIAGNOSED WITH GLAUCOMA IN THE PAST 2 YEARS? YES / NO

IF YES, PLEASE LIST THE APPROPRIATE ICD-9 CODE ICD9 CODE_____

IS THE PATIENT PRESCRIBED MEDICATION TO TREAT GLAUCOMA YES / NO

IF YES, PLEASE INCLUDE THE NAME OF THE DRUG PRODUCT DRUG_____

COMMENTS:

PRESCRIBER SIGNATURE _____ **DATE** _____

By Signature, the Prescriber confirms the criteria information above is accurate, verifiable by client records and available for review upon request.

FAX OR MAIL TO:

FAX NUMBER 1-800-390-0109
HERITAGE INFORMATION SYSTEMS
ATTN: RI PRIOR AUTHORIZATION UNIT
PO BOX 25719
RICHMOND, VA 23286-8212
TELEPHONE NUMBER 1-866-420-3874

CALL CENTER HOURS
MONDAY – FRIDAY 9:00 AM – 6:00 PM (EST)
FAX NUMBER 1-800-390-0109 (AVAILABLE 24 HOURS)